MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09369

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.; LENGTH OF STAY (in this place) 22 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton Md; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Nellie (Middle) E. (Last) ARMIGER

4. DATE OF DEATH: (Month) Oct (Day) 5. (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec 2 1880

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Churchton, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D Nieman

14. MOTHER'S MAIDEN NAME: Luvenia Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mrs Louise Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis & Myocardial Insufficiency	3 yrs
443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	unknown
93d	(c) Hypertension	3 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1949, to Oct 5, 1949, that I last saw the deceased alive on Oct 5, 1949, and that death occurred at 10:55 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George C Basil	M. D.	Annapolis Md	10-5-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 8 1949	Woodfields Mem	Galesville	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 7, 1949	J. A. Dorsch	D. A. Gardner & Son	

RECEIVED
OCT 18 1949
BUREAU V. S.

09370

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN
LENGTH OF STAY (in this place) 8 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 HILLCREST AVE

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN
STREET ADDRESS (If rural give location) 413 HILLCREST AVE

3. NAME OF DECEASED (Type or Print) (First) ERNEST (Middle) SOMMERS (Last) BOEHLEIN

4. DATE OF DEATH (Month) October (Day) 18 (Year) 1949

5. SEX MALE
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 12/22/1891
9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER
10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD
11. BIRTHPLACE (State or foreign country) ELKRIDGE Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLES BOEHLEIN
14. MOTHER'S MAIDEN NAME LAURA VERMILLION

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1/2/1909 1/3/1912
16. SOCIAL SECURITY No. 705-10-6386
17. INFORMANT NORA A. BOEHLEIN - 413 HILLCREST AVE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a (c)

INTERVAL BETWEEN ONSET AND DEATH: First attack 3 years ago.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 5, 1941, to Oct. 18, 1949, that I last saw the deceased alive on Oct. 18, 1949, and that death occurred at 5:05 P.m., from the causes and on the date stated above.

SIGNATURE H. P. Friedman (Degree or title) M. D.
ADDRESS 1319 Light St. - Balt. 30.
DATE SIGNED 10/19/49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 10/21/49
NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL
LOCATION (City, town, or county) (State) BALTIMORE Md

DATE REC'D BY LOCAL REG. Oct 19 - 1949
REGISTRAR'S SIGNATURE C. W. Hedrick
24. FUNERAL DIRECTOR Robt C. & B. M. Walters
ADDRESS Pratt and Stricker Sts

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09371

CERTIFICATE OF DEATH

Reg. Dist. No. 2-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 1 School Street

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Margaret (Last) Brown

4. DATE OF DEATH: (Month) Oct. (Day) 17, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 17, 1890

9. AGE last birthday: 59 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Louis M. Melcher

14. MOTHER'S MAIDEN NAME: Grace E. Norwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Wm. H. Brown, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 3 weeks

331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
83a (b) Hypertension — 2 years
(c) Arteriosclerosis (Moderate) — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 20, 1949, to Oct 17, 1949, that I last saw the deceased alive on Oct 17, 1949, and that death occurred at 8 P m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
George C. Basil | M. D. | Annapolis Md | 10-18-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 10-20-49 | NAME OF CEMETERY OR CREMATORY: Cedar Bluff | LOCATION (City, town, or county): Annapolis (State): Md.

DATE REC'D BY LOCAL REG.: Oct. 20, 1949 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: John W. Taylor & Son | ADDRESS: Annapolis Md.

VS. A15

RECEIVED
OCT 21 1949
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09372

21

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills
LENGTH OF STAY (in this place): 32 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Old Annapolis Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills
STREET ADDRESS (If rural, give location): Old Annapolis Road

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Sewell (Last) Clark Jr.

4. DATE OF DEATH: (Month) October (Day) 27 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 15 1880

9. AGE last birthday: 69 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Severn A.A.Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John S. Clark

14. MOTHER'S MAIDEN NAME: Margaret Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Joseph T. Ryan (Son-in-law)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary Thrombosis — 15 Min

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease — 2 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20, 1949, to Oct 27, 1949, that I last saw the deceased alive on Oct 20, 1949, and that death occurred at 12:55A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward J Chenett M.D. Gambrills Md 10-27-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Oct. 29, 1949 | NAME OF CEMETERY OR CREMATORY: Baldwin Memorial | LOCATION (City, town, or county) (State): Severn Crossroads, A.A.Co. Md.

DATE REC'D BY LOCAL REG. 10-28-49 | REGISTRAR'S SIGNATURE: A.W. Redinel | 24. FUNERAL DIRECTOR: Thomas W. Singleton | ADDRESS: Glen Burnie

AGE: Army discharge & marriage cer. Filmed G 122 10/10/49 LL

09373

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 27

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: FT. Geo. G. Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Station Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fifth Street Box 163
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Clyde V. Collins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Olive Mae Collins
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): April 10, 1911

8. AGE: Years	Months	Days	If less than one day
38	5	21	hrs. min.

9. Birthplace: Stonage, Va. (Town, county, and state)
10. Usual occupation: Sgt.
11. Industry or business: U.S. Army

FATHER
12. Name: MART Collins
13. Birthplace: Not Known

MOTHER
14. Maiden name: MARTHA BANKS
15. Birthplace: Not Known

16. Informant: Mrs. Olive Collins
Address: Fifth St. Odenton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 4, 1949 (month) (day) (year)
Cemetery or crematory: Gambrills Cemetary
Location: Gambrills, Maryland
18. Funeral director: Lilly & Zeiler, Inc
Address: Baltimore, Maryland

19. 4 October 1949 (Date rec'd by registrar) James E Hayes
JAMES E. HAYES, Captain

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT 1 1949 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 1st 1949, to Oct 1 1949
and that I last saw h... alive on Oct 1st 1949

Immediate cause of death: Fracture, skull, with subdural hemorrhage — DURATION: 3 hr 10 M

Due to:

Due to:

Other conditions: Fractured ribs, bilateral. Ruptured liver
(Include pregnancy within 3 months of death)

Major findings of operations: 825.6 170c — Date of op.
Autopsy results: See above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Oct 1
Where did injury occur? Old Route 40 (City or town) outside Ellicott City (County) Md. (State)
Injured at home, farm, industry, public place (where?): Old Route 40
Means of injury: Car wreck Injured at work? no

23. SIGNATURE: Lee M. Howard, M.D.
LEE M HOWARD MD (M. D. or other)
Address: Ft. Geo. Meade, Md. STATION HOSPITAL Date signed: 10/1/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
OCT 6 1949
BUREAU V. S.

09374

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Mathias (Middle) (Last) Cook
4. DATE OF DEATH (Month) Oct. (Day) 15 (Year) 1949
5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH Oct. 15, 1878 | 9. AGE last birthday 71 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Annapolis Neck, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mathias Cook | 14. MOTHER'S MAIDEN NAME Celia Cook
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Goldie Groom

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lobar Pneumonia, L. base — INTERVAL BETWEEN ONSET AND DEATH 4-5 days.

151 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (Thought to have been a terminal affair)

46b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Stomach

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-13, 1949, to 10/15, 1949, that I last saw the deceased alive on 10/14, 1949, and that death occurred at 8 40 A m., from the causes and on the date stated above.

SIGNATURE Maurice H. Lawrence, M.D. (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 10/16/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Oct. 18, 1949 | NAME OF CEMETERY OR CREMATORY Asbury | LOCATION (City, town, or county) Smithville (State) Md.

DATE REC'D BY LOCAL REG. Oct. 18, 1949 | REGISTRAR'S SIGNATURE Wm. Trench | 24. FUNERAL DIRECTOR William Leese, II Annapolis, Md. | ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09375

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 922 Center Street

3. NAME OF DECEASED (Type or Print) (First) Jane (Middle) (Last) Diggs

4. DATE OF DEATH (Month) Oct. (Day) 7 (Year) 1949

5. SEX Female

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH 1887

9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Chesterfield md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Isaac Queen

14. MOTHER'S MAIDEN NAME Annie Queen.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Louise Diggs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intestinal Obstruction — Interval Between Onset and Death

570.5 Antecedent cause(s)

122b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) Annapolis (COUNTY) A A (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-30-49, to 10-6-49, that I last saw the deceased alive on 10-5-49, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE E. T. Talbert (Degree or title) M.D ADDRESS 10 Carroll DATE SIGNED 10-10-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Oct. 10, 1949 NAME OF CEMETERY OR CREMATORY Brewer Hill LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Oct 10, 1949 REGISTRAR'S SIGNATURE W. O. Munch

24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis Md.

RECEIVED
OCT 11 1949
BUREAU V. S.

09376

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) D.O.A
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
STREET ADDRESS (If rural, give location) Davidsonville Road.

3. NAME OF DECEASED (Type or Print) (First) RACHAEL (Middle) ANN (Last) DORSEY
4. DATE OF DEATH (Month) Oct. (Day) 8 (Year) 1949
5. SEX Female
6. COLOR OR RACE negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH May 26, 1949
9. AGE last birthday yrs. If under 1 year Months 4 Days 13 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benj. Dorsey
14. MOTHER'S MAIDEN NAME Gertrude Anderson.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Benj. Dorsey.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Strangulation

925.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Nipple used as pacifier got stuck in Childs throat

195d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
(CITY OR TOWN) Gambrills (COUNTY) A. A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 8, 1949 6 45 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Nipple got stuck in infants throat

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D., (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis Md DATE SIGNED 10-8-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 11, 1949
NAME OF CEMETERY OR CREMATORY Mt. Tabor
LOCATION (City, town, or county) Mt Tabor (State) Maryland

DATE REC'D BY LOCAL REG. Oct 10, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son ADDRESS 45 Northwest

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09377

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Balti.City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 21 years 5 mos.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1952 Walbrook Avenue
3. NAME OF DECEASED (Type or Print) (First) Elsie (Middle) (Last) Duppins	4. DATE OF DEATH (Month) (Day) (Year) October 12, 1949
5. SEX: female — 6. COLOR OR RACE: colored — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single — 8. DATE OF BIRTH: about 1880 not known	9. AGE last birthday: 61(?) yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laundress — 10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Richard Duppins	14. MOTHER'S MAIDEN NAME: Not known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ***** — 16. SOCIAL SECURITY NO.: **********	17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Degeneration (Coronary Disease)	known for 4 months
420.1 Antecedent cause(s)	(b)	
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Schizophrenia, Paranoid Type	since admission

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: *****	19b. MAJOR FINDINGS OF OPERATION: *****	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): ****	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ** (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour): *** m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ***

22. I hereby certify that I attended the deceased from April 22, 1928, to Oct. 12, 1949, that I last saw the deceased alive on 10/12/49, 19....., and that death occurred at 5:30P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M.D.	Crownsville, Maryland	10/12/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
buried	10/15/49	Mt. Auburn	Baltimore Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/13.49	E. F. Joyce	Virgie B. Ringgold	1463 N. Carey St. Balto Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 15 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09380

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS ~~Deceased~~

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side.
STREET ADDRESS (If rural, give location) private road.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	none given		Oct.	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	~~White~~	—	Oct. 13. 1949	yrs.				10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Walter Edland	Laura Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Laura Lee

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Premature infant (4½ or 5 months)	
776 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
159	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Claffy M.D.	Deputy Medical Examiner	Annapolis Md	10-13-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 14 1949	South Shore	Shady Side	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 14	D. B Dent	T. A. Hardesty & Son	Galesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 15 1949
BUREAU V. S.

Forney "A" Boy 1007

~~Birth + Death~~ Death 09378

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ Death

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Anne Arundel

City or town Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:
Emergency Hospital

Length of mother's stay in County Life
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Anne Arundel

City or town Odenton
(If outside city or town limits, write RURAL and give nearest town)

Street No. Telegraph Road
(If RURAL give LOCATION)

3. Name of child John Forney (Baby "A")

4. Date of birth Oct 6, 1949 Hour 6:25 ~~P~~ A.M.

5. Sex Male | 6. Twin or triplet Twin

7. No. of weeks pregnancy ~~xx~~ 18

FATHER OF CHILD

8. Full name Herbert H. Forney

9. Color W. 10. Age at time of this birth 30 yrs.

11. Usual occupation Machinist

MOTHER OF CHILD

12. Full maiden name Vanie L. Stinchcomb

13. Color W. 14. Age at time of this birth 23 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3

(b) How many other children were born alive but are now dead? 1 (c) How many other children were *born* dead? 0

17. Did child die before labor? No. During labor? No

18. Pregnancy, complications of

19. Labor: (a) Complications of

(b) Induced?

20. (a) Was there an operation for delivery? No
(Yes or No)

(b) State all operations, if any

(c) Did child die before operation?

During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity 4½ mo

(b) Maternal causes

776

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

159

Signature Edward J. Merritt M.D.
(Specify if M. D., midwife, or other)

Address Gambrills, Md.

23. (a) Friday (b) Date thereof Oct. 7 1949
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven

24. (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie, Md.

25. (a) Oct. 14, 1949 (b) [signature]
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

V. S. A10

* See Instruction C on stub.

Baby A Lived 3 Hours 30 Min

RECEIVED
OCT 29 1949
BUREAU V. S.

Forney "B" Boy
12 3

Birth + Death 09379

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County ANNE ARUNDEL
   City or town ANNAPOLIS, MD
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution:
   EMERGENCY HOSPITAL
   Length of mother's stay in County Life
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State MARYLAND
   County ~~ODENTON~~ A.A.
   City or town ODENTON.
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. TELEGRAPH ROAD
   (If RURAL give LOCATION)

3. Name of child Joseph FORNEY (BABY B)
4. Date of birth OCT. 6 1949 Hour 6.25 P M.
5. Sex MALE | 6. Twin or triplet TWIN
7. No. of weeks pregnancy ~~20~~ 18

FATHER OF CHILD

8. Full name HERBERT H. FORNEY
9. Color WH. 10. Age at time of this birth 30 yrs.
11. Usual occupation MACHINIST

MOTHER OF CHILD

12. Full maiden name MARIE L. STINCHCOMB
13. Color WH. 14. Age at time of this birth 25 yrs.
15. Usual occupation HOUSEWIFE.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3
(b) How many other children were born alive but are now dead? 1 (c) How many other children were *born* dead? 0

17. Did child die before labor? NO During labor? ~~YES~~ NO
18. Pregnancy, complications of
19. Labor: (a) Complications of
(b) Induced?
20. (a) Was there an operation for delivery? NO (Yes or No)
(b) State all operations, if any.
(c) Did child die before operation?
During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes Prematurity 4 1/2 Mo
(b) Maternal causes
776

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
159
Signature Edward J. Hewitt M.D.
(Specify if M. D., midwife, or other)
Address GAMBRILLS, MD.

23. (a) BURIAL (b) Date thereof OCT. 7, 1949
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
24. (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie MD.

25. (a) Oct. 14, 1949 (b) [signature] Registrar
(Date rec'd by registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
Health Officer, per

* See Instruction C on stub.

V. S. A10

Baby B Lived 2 Hours 20 Min

RECEIVED
Oct 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09381

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Prince Geo St

3. NAME OF DECEASED (Type or Print): (First) Carrie (Middle) B. (Last) Golder
4. DATE OF DEATH: (Month) 10 (Day) 25 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: 12-4-1864
9. AGE last birthday: 84 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John Nunsen
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs J Willis Martin Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of right breast with extensive metastasis approx 2 yrs

170 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
50 (b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 19 49, to 25 Oct, 19 49, that I last saw the deceased alive on Oct, 19 49, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
Edward H. Hooker | M.D. | 53 Cornhill Annapolis, Md. | 26 Oct 1949.

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)
Burial | 10-27-49 | St Annes | Annapolis Md.

DATE REC'D BY LOCAL REG. Oct. 27, 1949 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS
John W. Taylor Son | Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 28 1949
BUREAU V. R.

09382

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) 10 minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1902 Naylor Road S.E.

3. NAME OF DECEASED (Type or Print) (First) LOUIS (Middle) EDWIN (Last) GOODRICH
4. DATE OF DEATH (Month) Oct. (Day) 9 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Mar. 1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Naval Gun Factory
10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
11. BIRTHPLACE (State or foreign country) Lynchburg, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT Paul E. Goodrich

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	unknown
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 10-9-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 12/49
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) Prince Geo (State) Maryland
DATE REC'D BY LOCAL REG. Oct 9, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J. William Lee & Sons ADDRESS Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 09383

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 1 yr. 2 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1643 Abbott Street

3. NAME OF DECEASED (Type or Print): (First) Indiana (Middle) (Last) Gray

4. DATE OF DEATH: (Month) 10/31/49 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: not known

9. AGE last birthday: 66(?) yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Madison Power

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ******

16. SOCIAL SECURITY NO.: ******

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	known since 10/31/49
331 Antecedent cause(s)	(b) General Arteriosclerosis	known since admission
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ******
19b. MAJOR FINDINGS OF OPERATION: ******
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ******
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ******
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): ****** m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ******

22. I hereby certify that I attended the deceased from 8/24/49, 19....., to 10/31/49, 19....., that I last saw the deceased alive on 10/31/49, 19....., and that death occurred at 10:45P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Morgenstern M.D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 10/31/49

23. BURIAL, CREMATION, REMOVAL (Specify): B. — DATE: Nov. 4-1949 — NAME OF CEMETERY OR CREMATORY: Mt. Calvary — LOCATION (City, town, or county) (State): A.A. Co. Md.

DATE REC'D BY LOCAL REG.: 11/3/49 — REGISTRAR'S SIGNATURE: A.W. Pedrick

24. FUNERAL DIRECTOR — ADDRESS: Byron T. Marnie Wright, 721 Aisquith St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09384

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): - - - - -
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 8 Maryland Avenue

3. NAME OF DECEASED (Type or Print): (First) Dorothy (Middle) Whiting (Last) GULLIVER

4. DATE OF DEATH: (Month) 10 (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 10-13-1890

9. AGE last birthday: 58 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - -

11. BIRTHPLACE (State or foreign country): Maine

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Whiting

14. MOTHER'S MAIDEN NAME: Grace Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hemorrhage, Cerebral	15 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Malignant Arterial Hypertension	years
	(c)	

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION: - - - - -

19b. MAJOR FINDINGS OF OPERATION: -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - -

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: - - - - - - -

(CITY OR TOWN) (COUNTY) (STATE): - - - - - - - - - - - - - - - - - -

TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 9-21-, 19.49., to 10-3-, 1949., that I last saw the deceased alive on 10-3-, 19.49., and that death occurred at 11:25A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
G.M. DAVIS	CDR., MC, USN	U.S.Naval Hospital, Annapolis, Md.	10-3-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	10-5-49	Arlington National	Arlington	Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
Oct. 5, 1949		John M. Taylor & Son	Annapolis Md.

RECEIVED
OCT 6 1920
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: AIS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Stroet, Baltimore

09385 22

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Gaskins

4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: Colred. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Feb. 1865 | 9. AGE last birthday: 84 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer | 10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R. R. | 11. BIRTHPLACE (State or foreign country): Lancaster, Va. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Gaskins | 14. MOTHER'S MAIDEN NAME: Mary (unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Ella Rose Gaskins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arterio-sclerotic Heart Disease — 3 weeks.

Antecedent cause(s) Uremia

592 / 131 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Nephritis — Unknown.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1947, to Oct 21, 1949, that I last saw the deceased alive on Oct 20, 1949, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Edward Merritt M.D. — Gambrills Md — Oct 22, 1949.

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Burial — Oct 25 1949 — Forks Cemetery — Patuxent — Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS

Oct. 25, 1949 — Clara Kasluf — J. B. Hanson — Annapolis

REC'D
NOV 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09386

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 3 mos. 2 Wks.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore,
STREET ADDRESS (If rural, give location): 1731 N. Carey Street

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Daniel (Last) Hall

4. DATE OF DEATH: (Month) 10/26 (Day) /49 (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: (Month) about 189? (Day) not known (Year)

9. AGE last birthday: 58 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Willie Hall

14. MOTHER'S MAIDEN NAME: Carrie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: *****

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Genefal Paresis — Interval between onset and death: known

025 Antecedent cause(s)

30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — since admission

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: --

19b. MAJOR FINDINGS OF OPERATION: ----

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ---

(CITY OR TOWN): **** (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): ---- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 7/4/49, 19....., to 10/26/49, 19....., that I last saw the deceased alive on 10/26/49, 19....., and that death occurred at 7:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M. D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 10/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct 31/1949 — NAME OF CEMETERY OR CREMATORY: Balt. National — LOCATION (City, town, or county) (State): Baltimore

DATE REC'D BY LOCAL REG.: 10/28/49 — REGISTRAR'S SIGNATURE: A.W. Hedrick

24. FUNERAL DIRECTOR: Geo. A. Kelson — ADDRESS: 1303 Eutaw

09387

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 College Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 10 College Ave.

3. NAME OF DECEASED (Type or Print) (First) Sophia (Middle) (Last) Harris
4. DATE OF DEATH (Month) Oct. (Day) 19 (Year) 1949

5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced
8. DATE OF BIRTH 8-25-1876
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Harris
14. MOTHER'S MAIDEN NAME Charlotte Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT William Watkin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Apoplexy

Antecedent cause(s) (b) Hypertensive Cardio Vascular Disease — 1 wk

443
93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-10-49, 19..., to 10-19, 1949, that I last saw the deceased alive on 10-19, 1949, and that death occurred at 12:50P m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS 40 Northwest Street DATE SIGNED 10-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Oct. 23, 1949
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Oct. 23, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR William Reese, II
ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

09388

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Fairfax · Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Fairfax Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Mary G Hillborn

3. (b) Social Security Number

4. Sex Female
5. Color or race W
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Harry G Hillborn
B.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) May 5 - 1865

8. AGE: Years 84 Months 5 Days 14 If less than one day ... hrs. ... min.

9. Birthplace Penna (Town, county, and state)
10. Usual occupation home
11. Industry or business
FATHER 12. Name Ford Burke
13. Birthplace unknown
MOTHER 14. Maiden name Lydia Thompson
15. Birthplace unknown
16. Informant Mrs Florence Bausum
Address R Ed. 4 Box 1094 Annapolis Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct 22 - 49 (month) (day) (year)
Cemetery or crematory Woodlawn
Location Baltimore Md
18. Funeral director Frank W Seitz
Address 814 W 36th St
19. 10/20 19 49 (Date rec'd by registrar) D W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1949 at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1, 1949 to Oct 19 1949
and that I last saw h... alive on Oct 19, 1949 19
Immediate cause of death Acute Dilatation of the Heart — DURATION Immediate
Due to (unknown)
Due to
Other conditions Arteriosclerotic Cardio-vascular disease — 2 yrs
(Include pregnancy within 3 months of death)
Major findings of operations 434.3
Date of op. 930
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson MD M. D. or other
Address Annapolis, Md Date signed 10/19/49

VS-A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09389

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) two months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington, Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) 12 Bony Castle Avenue ✓

3. NAME OF DECEASED (Type or Print) (First) William	(Middle) Donald	(Last) Hopkins	4. DATE OF DEATH (Month) 10/13/49 (Day) (Year) 19	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) separated	8. DATE OF BIRTH Dec. 30, 1902	9. AGE last birthday 46 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Blanche Hopkins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ***** (If year, give war or dates of service) *****	16. SOCIAL SECURITY NO. *****	17. INFORMANT Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known
025 Antecedent cause(s)		since
30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	admission
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION *****	19b. MAJOR FINDINGS OF OPERATION ***	20. AUTOPSY? ******* Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) *******	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ***	(CITY OR TOWN) ******* (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ***** m.	INJURY OCCURRED While at ***** Not While Work ☐ At work ☐	HOW DID INJURY OCCUR? *****

22. I hereby certify that I attended the deceased from 7/12/49, 19....., to 10/13/49, 19....., that I last saw the deceased alive on 10/13/49, 19....., and that death occurred at 7:25 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Mangerstein	M.D.	Crownsville, Maryland	10/13/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE Oct 15	NAME OF CEMETERY OR CREMATORY Sandy Spring Md	LOCATION (City, town, or county) (State) Montgomery Co
DATE REC'D BY LOCAL REG. 10-13-49	REGISTRAR'S SIGNATURE E. Joyce Local Reg.	24. FUNERAL DIRECTOR Robert L. Snowden	ADDRESS Rockville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09390

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) James (Middle) A. (Last) Insey
4. DATE OF DEATH (Month) Oct. (Day) 6 (Year) 1949
5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Dec. 23 1888
9. AGE last birthday 60 yrs. If under 1 year Months 9 Days 13 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Insey
14. MOTHER'S MAIDEN NAME Jannie Insey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no. (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Bessie Insey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerotic C. V. Disease & Decompensation — 1-2 yrs.

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to Oct 6, 1949, that I last saw the deceased alive on Oct 3, 1949, and that death occurred at 4:50 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Marvin Klawans — ADDRESS Annapolis, Md — DATE SIGNED 10/6/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Oct. 8, 1949 — NAME OF CEMETERY OR CREMATORY Broadneck — LOCATION (City, town, or county) St. Margretts (State) Md.

DATE REC'D BY LOCAL REG. Oct. 7, 1949 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR J. B. Johnson — ADDRESS Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 8 1949
BUREAU V. S.

3 copies

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09391

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
LENGTH OF STAY (in this place) 5 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1604 Mey Ct, Douglas Balto 31

3. NAME OF DECEASED (Type or Print): (First) DOLLY (Middle) MAE (Last) JOHNSON

4. DATE OF DEATH: (Month) October (Day) 14 (Year) 1949

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: July 1, 1923

9. AGE last birthday: 26 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HENRY EVANS

14. MOTHER'S MAIDEN NAME: WILLIE WARREN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Crownsville State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Caseous pneumonia of right lung — Interval between onset and death: 5 weeks

002

Antecedent cause(s)

131b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Tuberculosis

(c) Hallucinosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Alcoholic Hallucinosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 22nd 1949, to October 1st 1949, that I last saw the deceased alive on Octobe 14 1949, and that death occurred at 2 05 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Asst Manager Md — Crownsville State Hospital — 10/4/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Oct 6 1949

NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery

LOCATION (City, town, or county) (State): A A Co Md

DATE REC'D BY LOCAL REG. 10/6/49

REGISTRAR'S SIGNATURE: A W Fedrick

24. FUNERAL DIRECTOR: Robert E Williams

ADDRESS: 1515 McElderry St

VS. A15

Dr. A. T. Allen

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09392

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Best Gate
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Best Gate
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Pearline (Middle) (Last) Jones
4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: July 4 1898
9. AGE last birthday: 51 yrs. If under 1 year: Months 9 Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Hall
14. MOTHER'S MAIDEN NAME: Hester Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James M. Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uterine Carcinoma

174 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
48b (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-22-44, 19..., to 10-22-49, 19..., that I last saw the deceased alive on 10-22-49, 19..., and that death occurred at 5.50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
A. T. Allen M D 10 Carroll 10-24-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 26 1949
NAME OF CEMETERY OR CREMATORY Dowlers
LOCATION (City, town, or county) (State) Best Gate Md.

DATE REC'D BY LOCAL REG. October 25, 1949
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR J. B. Johnson ADDRESS

VS. A15

RECEIVED
27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09393

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL - Annapolis
STREET ADDRESS (If rural give location): Route #1, Box 100

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Othel	Allen	JORDON	10	25	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Single	7-9-49	0 yrs.	3	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James S. Jordon
14. MOTHER'S MAIDEN NAME: Julia Jean Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) BACTEREMIA, ORIGIN UNKNOWN	
571.0 / 119a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) DIARRHEA	2 days
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	MENINGISMUS	2 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-23- , 19 49, to 10-25- , 19 49, that I last saw the deceased alive on 10-25- , 19 49, and that death occurred at 11:05 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
E.R. MOELLER CDR, MC, USN	U.S. Naval Hospital, Annapolis, Md.	10-26-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county)	(State)
Burial	Oct. 29, 1949	Brewer Hill	Annapolis	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/27/49	A.W. Hedrick	William Reese, II	Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09394

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): Cooper Apts.

3. NAME OF DECEASED (Type or Print): (First) Georgiana (Middle) (none) (Last) KARMANY

4. DATE OF DEATH: (Month) 10 (Day) 4 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 10-28-1871

9. AGE last birthday: 77 yrs. If under 1 year: Months 11 Days 6 If under 24 hrs.: Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Connecticut

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William B.B. Edwards

14. MOTHER'S MAIDEN NAME: Lucy Beebe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Thrombosis Cerebral	Few days
332 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83b	(b) Arteriosclerosis, General	Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive, Vascular Disease

19a. DATE OF OPERATION: – – – –

19b. MAJOR FINDINGS OF OPERATION: –

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): – – – –

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): – – – – (CITY OR TOWN) – – – – (COUNTY) – – – – (STATE) – – – –

TIME OF INJURY (Month) (Day) (Year) (Hour): – – – – – – m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? – – – – – – – – – – – – – – – – – –

22. I hereby certify that I attended the deceased from 6-25- , 1949 , to 10-4- , 1949 , that I last saw the deceased alive on 10-4- , 1949 , and that death occurred at 9:35A m., from the causes and on the date stated above.

SIGNATURE: G. M. Davis — (Degree or title): CDR,MC,USN — ADDRESS: U.S.Naval Hospital,Annapolis,Md. — DATE SIGNED: 10-4-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 7, 1949	Naval Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 6, 1949	[signature]	Ben L. Hopping and Son	Annapolis, Md.

RECEIVED
OCT 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09395

Reg. Dist. No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
LENGTH OF STAY (In this place) 18 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railroad Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
STREET ADDRESS (If rural, give location) Railroad Ave.

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) ROBERT (Last) KISER

4. DATE OF DEATH: (Month) Oct. (Day) 20 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 7, 1894

9. AGE last birthday: 54 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steam fitter

10b. KIND OF BUSINESS OR INDUSTRY: General Contract

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Joseph R. Kiser

14. MOTHER'S MAIDEN NAME: Lethia Fox.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-03-9299

17. INFORMANT: Grace Kiser

18. MEDICAL CERTIFICATION

		Interval Between Onset and Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
581.1 Immediate cause	(a) Acute Cardiac Failure	sudden
124a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cirrhosis of Liver	unknown
	(c) Acute Alcoholism	1 week
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Slow Nasal Hemorrhage	1 week

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffey (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 10-20-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF October 22 | NAME OF CEMETERY OR CREMATORY Glen Haven | LOCATION (City, town, or county) Glen Burnie (State)

DATE REC'D BY LOCAL REG. 10/21/49 | REGISTRAR'S SIGNATURE L. J. Wallace

24. FUNERAL DIRECTOR: Thomas W. Singleton ADDRESS Glen Burnie

RECEIVED
OCT 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09417

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
LENGTH OF STAY (in this place) 1 1/2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 26 Oakwood Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS (If rural give location) 26 Oakwood Ave

3. NAME OF DECEASED (Type or Print) (First) Sallie (Middle) Winchester (Last) Joring

4. DATE OF DEATH (Month) October (Day) 14 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH Jan 17 1861

9. AGE last birthday 87 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John H. Winchester

14. MOTHER'S MAIDEN NAME Sarah Ellen Mahoney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Thomas I. Joring (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Generalized carcinomatosis	2 years
170 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 50	(b) Carcinoma of breast	6 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1944

19b. MAJOR FINDINGS OF OPERATION Right breast removed

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1949, to Oct 14, 1949, that I last saw the deceased alive on Oct 14, 1949, and that death occurred at 10:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert S. McCreary M.D.		402 Main St Laurel Md	10/14/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	October 19 49	Falls Church Cem.	Falls Church, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/15/49	L. J. DeAlba	Thomas W. Singleton	

VS. A15

RECEIVED
OCT 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09396 35

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A.A.
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A.A.
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Orchard Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ROSE ANNA LOWERY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife Lawrence A.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6/7/1873

8. AGE: Years	Months	Days	If less than one day
76	4	22	..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home
FATHER 12. Name Christofer Strauss
13. Birthplace
MOTHER 14. Maiden name Barbara ?
15. Birthplace
16. Informant Family
Address Same
17. B (Burial, cremation, or removal. Which?) Date thereof 11/2/49 (month) (day) (year)
Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.
18. Funeral director Joseph L. McCauley
Address 130 E. Fort Ave.
19. 11-1-49 19..... L (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29th 19 49 at 9:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 19.. to Oct 1949 19.. and that I last saw h.. alive on Oct 29th 1949 19..

Immediate cause of death	DURATION
Terminal Bronchopneumonia →	12 hours
Due to Hypertensive Cardiovascular Disease. →	10-15 yrs.
Due to Generalized arteriosclerosis →	10-15 yrs
Other conditions	
413	
93d (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas E. Ang M.D. M. D. or other
Address 642 Nat. Bk. Bldg. Date signed 10-31-49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09397

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 1 day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital	STREET ADDRESS (If rural give location) 544 Park Avenue ✓

3. NAME OF DECEASED (Type or Print)	(First) Frank	(Middle) none	(Last) LYON	4. DATE OF DEATH	(Month) 10	(Day) 16	(Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4-23-1874	9. AGE last birthday 75 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Hylan Benton Lyon	14. MOTHER'S MAIDEN NAME Grace Machen						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I & II	16. SOCIAL SECURITY No. - - -	17. INFORMANT Hospital Records					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) THROMBOSIS, CORONARY ARTERY	10 minutes
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) ARTERIOSCLEROSIS GENERAL	Several yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION - - - - - - -	19b. MAJOR FINDINGS OF OPERATION -	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - -	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - - -	(CITY OR TOWN) (COUNTY) (STATE) -
TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from Oct. 15, 1949, to Oct. 16, 1949, that I last saw the deceased alive on Oct. 16, 1949, and that death occurred at 3:40 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. G. Hamm W. G. HAMM	LT JG., MC, USNR	U.S. Naval Hospital, Annapolis, Md.	10-17-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 24, 1949	Arlington National	Arlington, Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 20, 1949	[signature]	B.L. Hopping and Son	Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 21 1949
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

BC

09398

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 2 and 1/2 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 2006 W. Lanvale Street

3. NAME OF DECEASED (Type or Print)	(First) Eunice	(Middle) A.	(Last) McMorris	4. DATE OF DEATH	(Month) 10/2/49 (Day) (Year) 19
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: 12/9/15	9. AGE last birthday: 33 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): South Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: William Gossett	14. MOTHER'S MAIDEN NAME: Bessie Windler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~(If yes, give war or dates of service)~~	16. SOCIAL SECURITY NO.: *******	17. INFORMANT: Hospi tal Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Catatonic Stupor	known for six days
300.3 Antecedent cause(s)		
84b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Paranoid Type	known since admission

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not reinted to the disease or condition causing death.

19a. DATE OF OPERATION: ******	19b. MAJOR FINDINGS OF OPERATION: *******	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): ******	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): *******	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): ***** m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ***

22. I hereby certify that I attended the deceased from 7/19/49, 19....., to 10/2/49, 19....., that I last saw the deceased alive on 10/2/49, 19....., and that death occurred at 11:30 P.m., from the causes and on the date stated above.

SIGNATURE: Jacob Margenstein M.D. (Degree of title) — ADDRESS: Crownsville, Maryland — DATE SIGNED: 10/2/49

23. BURIAL, CREMATION REMOVAL (Specify): Shipped	DATE: 10-7-1949	NAME OF CEMETERY OR CREMATORY: Newberry S.C.	LOCATION (City, town, or county) (State): Newberry S.C.
DATE REC'D BY LOCAL REG.: 10/7/49	REGISTRAR'S SIGNATURE: A. W. Hedrick	24. FUNERAL DIRECTOR: Mrs Katie R. Williams	ADDRESS: 322 N Schroeder St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09399

CERTIFICATE OF DEATH

CB Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel (Rural) LENGTH OF STAY (in this place) 22 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.
STREET ADDRESS (If rural give location) Family Deceased

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Pauline J. Moore

4. DATE OF DEATH (Month) (Day) (Year) 10- 29- 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 10-9-1892

9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None.

10b. KIND OF BUSINESS OR INDUSTRY ********

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Josephine Moore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT District Training School.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	10 years
152 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cancer of the Duodenum	10 years
46c	(c) Mental Deficiency (IDIOT)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/17/, 1949, to 10/29/, 1949, that I last saw the deceased alive on 10/28/, 1949, and that death occurred at 4:20 a.m., from the causes and on the date stated above.

SIGNATURE [signature] M.D. (Degree or title) M.D. ADDRESS District Training School DATE SIGNED Laurel Md

23. BURIAL, CREMATION REMOVAL (Specify) DATE Nov 1-49 NAME OF CEMETERY OR CREMATORY Dist Tr School LOCATION (City, town, or county) AACo Laurel (State) Md

DATE REC'D BY LOCAL REG. Nov 1-49 REGISTRAR'S SIGNATURE Clara Haslup

24. FUNERAL DIRECTOR Raymond L. Jones, ADDRESS Laurel Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09400

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Emily (Middle) Hollingsworth (Last) Murray

4. DATE OF DEATH: (Month) Oct. (Day) 8, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Jan. 1, 1863

9. AGE last birthday: 86 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Phila. Penna.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry M. Murray

14. MOTHER'S MAIDEN NAME: Mary H. Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Forbes Calhoun

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) lobar pneumonia	1 wk.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic cardiovascular disease	20 yrs.
	(c) R hemiplegia	18 mos.

422,1
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1945, to Oct. 7, 1949, that I last saw the deceased alive on Oct 6, 1949, and that death occurred at 8 20 P m., from the causes and on the date stated above.

SIGNATURE: S-Bowersmith (Degree or title) M.D. ADDRESS: Annapolis Md. DATE SIGNED: 10/8/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Oct. 9, 1949
NAME OF CEMETERY OR CREMATORY: Christ Church
LOCATION (City, town, or county) (State): Owensville, Md.

DATE REC'D BY LOCAL REG.: Oct 9, 1949
REGISTRAR'S SIGNATURE: Edward Colleman

24. FUNERAL DIRECTOR: T.A. Hardesty & Son
ADDRESS: Galesville, Md.

VS. A15

RECEIVED
OCT 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC 09401

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY ANNAPOLIS ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARNOLD
LENGTH OF STAY (in this place) 6 WEEKS
HOSPITAL OR INSTITUTION OR STREET ADDRESS PINES ON SEVERN - ARNOLD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural, give location) 2910 MONTEBELLO TERRACE ✓

3. NAME OF DECEASED (Type or Print) (First) ANIE (Middle) MARIE (Last) NEWTON

4. DATE OF DEATH (Month) OCT. (Day) 9 (Year) 1949

5. SEX F.
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH JAN. 5, 1873
9. AGE last birthday 76 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN W. KEPLINGER
14. MOTHER'S MAIDEN NAME LUCY WELLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT MRS. NORMAN BROOKS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis Chr.	1 year
Antecedent cause(s)	(b) Coronary Insufficiency	6 months
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arterio Sclerosis generalized	unknown

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to Oct. 9, 1949, that I last saw the deceased alive on Oct. 7, 1949, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 10.9.49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 10/11/49 NAME OF CEMETERY OR CREMATORY Baltimore LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. 10-11-49 REGISTRAR'S SIGNATURE W. W. Hedrick arts
24. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St Paul St Balto. 2, Md.

09402

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jacobsville (Pasadena P.O.) — LENGTH OF STAY (in this place): 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rock Creek Road

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jacobsville (Pasadena P.O.)
STREET ADDRESS (If rural, give location): Rock Creek Road

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Elisabeth (Last) Oakley
4. DATE OF DEATH: (Month) Oct. (Day) 22, (Year) 1949

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Feb. 14, 1868
9. AGE last birthday: 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Berkley Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John T. Brent
14. MOTHER'S MAIDEN NAME: Ellen Wren

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert L. Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fractured Hip 3 years — 31 x 3 yrs

962 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) A1

930 (c) Heart failing (Acute myocarditis) 4 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Set Hip July 1946.
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1946 to October 22, 1949, that I last saw the deceased alive on Oct. 22, 1949, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

SIGNATURE: Thos. H. Phillips (Degree or title) 3337 — ADDRESS: Edmondson ave Baltimore 29 Md — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 10-25-49 — NAME OF CEMETERY OR CREMATORY: Glen Haven — LOCATION (City, town, or county) (State): Glen Burnie, A.A.Co. Md.

DATE REC'D BY LOCAL REG.: 10/24/49 — REGISTRAR'S SIGNATURE: L. J. Dallas
24. FUNERAL DIRECTOR: Thomas W. Singleton — ADDRESS: Glen Burnie

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09403

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 1 Wk. 4 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Mayland; COUNTY Balt.City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 917 Shield Place

3. NAME OF DECEASED (Type or Print): (First) Willie; (Middle); (Last) Cwens

4. DATE OF DEATH: (Month) 10/27/49; (Day); (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: about 1848 ~~not known~~

9. AGE last birthday: 31 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ******* (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. *****

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Schizophrenic Exhaustion — Interval Between Onset and Death: known since admission

Antecedent cause(s) 300.2

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 84b (b) Schizophrenia, Catatonic Type

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ***** 19b. MAJOR FINDINGS OF OPERATION *****

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ***** PLACE (Home, farm, factory, street, office bldg., etc.) ***** (CITY OR TOWN) ***** (COUNTY) ***** (STATE) *****

TIME OF INJURY: (Month) (Day) (Year) ***; (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? *****

22. I hereby certify that I attended the deceased from 10/17/49, 19....., to 10/27/49, 19....., that I last saw the deceased alive on 10/27/49, 19....., and that death occurred at 11:40 A. m., from the causes and on the date stated above.

SIGNATURE Jacob Brumgarten (Degree or title) M.D. ADDRESS Crownsville, Maryland DATE SIGNED 10/27/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE 11/1/49; NAME OF CEMETERY OR CREMATORY Mt Olivet; LOCATION (City, town, or county) Balto (State)

DATE REC'D BY LOCAL REG. 10/31/49; REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Wm C Jodson; ADDRESS 916 Pa.

65
20
45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09404

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN annapolis Md.; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY A A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Dorothy (Middle) Rebecca (Last) Parker

4. DATE OF DEATH: (Month) Oct (Day) 29 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Oct 29. 1949

9. AGE last birthday: yrs.; If under 1 year: Months, Days; If under 24 hrs.: Hours 2, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Parker

14. MOTHER'S MAIDEN NAME: Dorothy R. Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Henry Parker. Harwood Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Premature Infant. — Interval Between Onset and Death: 3 hrs

776 / 159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 1 sem

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/29/49, 19..., to ..., 19..., that I last saw the deceased alive on 10/29/49, 19..., and that death occurred at 7 P. ...m., from the causes and on the date stated above.

SIGNATURE Theodore A. Thorn (Degree or title) M.D. ADDRESS 40 Northland Street Annapolis Md DATE SIGNED 10/31/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Oct 31, 1949

NAME OF CEMETERY OR CREMATORY Chews

LOCATION (City, town, or county) (State) Davidsonville Md

DATE REC'D BY LOCAL REG. Oct 31, 1949

REGISTRAR'S SIGNATURE Mrs J. French

24. FUNERAL DIRECTOR T A Hardesty & Son

ADDRESS Galesville Md

RECEIVED
NOV 2 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09405

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md | COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 12 Lafayette Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Earnest		Parker	Oct	14	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	Colored	married	June 20 1884	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Harwood A. A. Co.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Parker	Sophia (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Randolph Parker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Stomach

151 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46 b (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 9-20, 1949, to 10-14, 1949, that I last saw the deceased alive on 10-13, 1949, and that death occurred at 7.30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
T. Allen	MD	10 Carroll	10-15-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct. 16 1949	Brewer Hill	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 15, 1949	[illegible]	J. B. Johnson	Annapolis

RECEIVED
OCT 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

09406

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place) 5 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Brown's Woods

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D. #2
STREET ADDRESS (If rural, give location) Brown's Woods

3. NAME OF DECEASED (Type or Print) (First) FRED (Middle) Alton (Last) PARKER
4. DATE OF DEATH (Month) Oct. (Day) 24 (Year) 1949
5. SEX M
6. COLOR OR RACE negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) —
8. DATE OF BIRTH May 19, 1949
9. AGE last birthday yrs. If under 1 year Months 5 Days 1 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Galloway Parker
14. MOTHER'S MAIDEN NAME Mildred Hunt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mildred Parker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Strangulation from	
921.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Regurgitation of vomitus	sudden
195d	(c) Accidental	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY at home
(CITY OR TOWN) near Annapolis (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Regurgitation of vomitus

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 10-20-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct. 20 1949
NAME OF CEMETERY OR CREMATORY Broadneck
LOCATION (City, town, or county) (State) St. Margrets
DATE REC'D BY LOCAL REG. Oct. 20, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 21 1949
BUREAU U. S.

Evidence for change in year of birth shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

BC 09407

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

FILM No. 6 A 22 OCT 20 1949

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
LENGTH OF STAY (In this place) 10 minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS at National Plastic Corp. property

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1220 So. Highland Ave.

3. NAME OF DECEASED (Type or Print) (First) GUYLE (Middle) BASCOME (Last) PATRICK
4. DATE OF DEATH (Month) Oct (Day) 11 (Year) 1949

5. SEX MALE
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH 11-8-49
9. AGE last birthday 36 yrs. 1912
If under 1 year Months Days
If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER
10b. KIND OF BUSINESS OR INDUSTRY WHITING-TURNER
11. BIRTHPLACE (State or foreign country) LEBANON, VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME CHARLES S. PATRICK
14. MOTHER'S MAIDEN NAME NANNIE McCOUGHLIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT ANNA PATRICK; 1220 S. HIGHLAND AVE.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Electrocution — INTERVAL BETWEEN ONSET AND DEATH: sudden

914.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

193 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY factory site
(CITY OR TOWN) Odenton (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Oct. (Day) 11 (Year) 194 (Hour) 7 40 a.m.
INJURY OCCURRED While at work ☑ Not while at work ☐
HOW DID INJURY OCCUR? Was operating mobile crain lifting steel girder contacted high tension

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis Md DATE SIGNED 10-11-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 10-14-49
NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.
LOCATION (City, town, or county) Eastern Ave Balto Co Md (State)

DATE REC'D BY LOCAL REG. Oct 13-1949
REGISTRAR'S SIGNATURE A. W. Hedrich
24. FUNERAL DIRECTOR Charles S. Zeiler ADDRESS 901 S. Conkling St. Balto. 24, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09408

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 73 Prince George St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 73 Prince George St.

3. NAME OF DECEASED (Type or Print): (First) ANNIE (Middle) MYRTLE (Last) SANDS

4. DATE OF DEATH: (Month) Oct. (Day) 12 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 18, 1876

9. AGE last birthday: 73 yrs. If under 1 year: Months 0 Days 24 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. William Sands

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis & Myocardial Insufficiency	2 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	2 years
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chr. Arthritis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to Oct. 12, 1949, that I last saw the deceased alive on Oct. 12, 1949, and that death occurred at 8:20 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George L. Buell	M. D.	Annapolis Md.	10-14-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 16, 49	Glen Haven Cemetery	Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 15, 1949	[signature]	B.L. Hopping and Son	Annapolis, Md.

VS. A15

RECEIVED
OCT 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

09409

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural - Pasadena PO. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Lake Shore - Camp Milbur
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Riviera
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Sylvan Shores
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Alice Isabel Schultz

3. (b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: ~~widowed~~ Married
6.(b) Name of husband or wife: Harry A Schultz
6.(c) If alive, give age: 81 years
7. Birth date of deceased (mo., day, yr.): JAN. 23rd. 1877

8. AGE: Years: 72 Months: 8 Days: 22 If less than one day: ..... hrs. ..... min.

9. Birthplace: Sandy Hook Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Home

FATHER
12. Name: Thomas Rearden
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. H. Monroe Helm
Address: Lake Shore - Pasadena, P.O. A.A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/18/49 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 10/17 1949 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15, 1949 approximately at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1948 to Oct. 2 1948 and that I last saw her alive on Oct. 2 1948

	DURATION
Immediate cause of death: Coronary thrombosis with myocardial infarction	Instant
Due to: Coronary arterio-sclerosis	Unknown
Due to: Generalized arterio-sclerosis	Unknown
Other conditions: Hypertension - moderate	

(Include pregnancy within 3 months of death)

Major findings of operations: None
420.1
94a
Date of op.: —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: A.F. Gaalaas M.D.
M. D. or other
Address: Pasadena P.O. Md. Date signed: 10/15/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH Be 09410

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel County — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): 600 Collett Street

3. NAME OF DECEASED (Type or Print): (First) Carrol (Middle) (Last) Snell

4. DATE OF DEATH: (Month) 10 (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1887

9. AGE last birthday: 62 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Howard County- Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Jim Snell

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — INTERVAL BETWEEN ONSET AND DEATH: Known to us since admission 9/28/45

Antecedent cause(s)

025
30 t

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/28/, 19.45., to 10/5/, 19.49, that I last saw the deceased alive on 10/4, 19.49., and that death occurred at 2:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M.D.

ADDRESS: Crownsville, Maryland

DATE SIGNED: 10/5/49

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE: 10/6/49 — NAME OF CEMETERY OR CREMATORY: Hospital a.a.Co. — LOCATION (City, town, or county) (State): Crownsville Md

DATE REC'D BY LOCAL REG: 10/6-49 — REGISTRAR'S SIGNATURE: E.T. Joyce Local Reg

24. FUNERAL DIRECTOR — ADDRESS: Supt. Hospital Crownsville Md

RECEIVED
OCT 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09411

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elvaton
LENGTH OF STAY (in this place) 27 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Millersville P.O. (rural)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elvaton
STREET ADDRESS (If rural, give location) Millersville P.O. (rural)

3. NAME OF DECEASED (Type or Print): (First) OLIVER (Middle) GRANT (Last) SPURRIER

4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Sept. 12 1873

9. AGE last birthday: 76 yrs.

If under 1 year: Months | Days
If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Moulder

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Grant Spurrier

14. MOTHER'S MAIDEN NAME: Sarah Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: No. 215-05-3564

17. INFORMANT: Elmira E. Spurrier

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Sclerosis	unknown
	(c)	

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 10-22-49

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial | DATE THEREOF: Oct. 24, 1949 | NAME OF CEMETERY OR CREMATORY: Glen Haven. | LOCATION (City, town, or county) (State): Glen Burnie, A.A.Co. Md.

DATE REC'D BY LOCAL REG. 10/24/49 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS: Thomas W. Singleton, Glen Burnie

RECEIVED
OCT 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 09412

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural
LENGTH OF STAY (In this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1520 E. Eager street

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Henry (Last) Stitt

4. DATE OF DEATH: (Month) October (Day) 2nd (Year) 1949

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: May 9, 1902

9. AGE last birthday: 47 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Monroe, North Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Antony Stitt

14. MOTHER'S MAIDEN NAME: Wilma Horn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Crownsville State Hospital, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) General Paresis	3½ months
Antecedent cause(s)		
025 30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 18th, 1949, to October 2nd, 1949, that I last saw the deceased alive on October 2nd, 1949, and that death occurred at 9:10 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M. D. ADDRESS Crownsville State Hospital DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): DATE October 5th 1949 NAME OF CEMETERY OR CREMATORY Mt. Olivet LOCATION (City, town or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. 10-3-49 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Mrs. George H. Holland ADDRESS 1631 Druid Hill Ave Baltimore

09413

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND Md
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis
STREET ADDRESS (If rural give location) 212 Claude St.

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Girl (Last) Suit
4. DATE OF DEATH (Month) Oct. (Day) 31 (Year) 1949
5. SEX F
6. COLOR OR RACE W
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 10-31-49
9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Annapolis Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Francis M. Suit
14. MOTHER'S MAIDEN NAME Marjorie Anderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Patent Ductus Arteriosus — INTERVAL BETWEEN ONSET AND DEATH 12 hrs

754.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

157e (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/31/49, 19....., to 10/31/49 19....., that I last saw the deceased alive on 10/31/49, 19....., and that death occurred at 4 A.M. m., from the causes and on the date stated above.

SIGNATURE Albert L. Anderson (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 11/1/49.

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 11-1-49 NAME OF CEMETERY OR CREMATORY St Marys LOCATION (City, town, or county) Annapolis (State) Md.

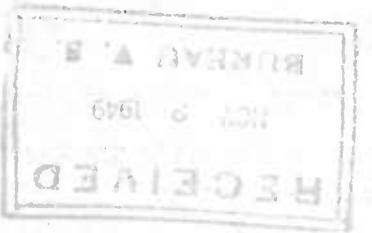
DATE REC'D BY LOCAL REG. Nov. 1, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I


RECEIVED
DEC 9 1949
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09414

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MAYO
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MAYO
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) (Last) TASKER

4. DATE OF DEATH: (Month) Oct (Day) 13, (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH: 12-25-77

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Friendship. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Robert Smith, Glenville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 1 day

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio - Sclerosis — 4 months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: X

19b. MAJOR FINDINGS OF OPERATION: X

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): X

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: X (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: X

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? X

22. I hereby certify that I attended the deceased from May 1st, 1949, to Oct. 13, 1949, that I last saw the deceased alive on Oct 13, 1949, and that death occurred at 7:09 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. D. Richardson M.D. 110 - Clay St, Glen Burnie, Md. 10/14/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE: OCT 16, 49 | NAME OF CEMETERY OR CREMATORY: MT. ZION CEM. | LOCATION (City, town, or county): Jotham | (State): Md

DATE REC'D BY LOCAL REG. Oct 15, 1949 | REGISTRAR'S SIGNATURE: Edward Collenson

24. FUNERAL DIRECTOR: T. E. Hardesty & Son | ADDRESS: Glenville Md.

RECEIVED
OCT 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09415

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park; LENGTH OF STAY (in this place) 3 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 215 Elizabeth Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco; STREET ADDRESS (If rural, give location) 215 Elizabeth Ave

3. NAME OF DECEASED (Type or Print): (First) IRVING (Middle) (Last) TAYLOR JR

4. DATE OF DEATH: (Month) OCT. (Day) 1 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: June 8. 1930

9. AGE last birthday: 19 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: IRVING TAYLOR, SR

14. MOTHER'S MAIDEN NAME: Lauretta Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Loretta Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Suffocation

916.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Burning Home

180 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home

(CITY OR TOWN) Patapsco Park (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) OCT. (Day) 1 (Year) 1949 (Hour) 5:30 Am.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? Home on fire and got trapped

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Coffy M.D. Deputy Medical Examiner Annapolis, Md. 10-1-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 10/4/49

NAME OF CEMETERY OR CREMATORY: Mt Calvary

LOCATION (City, town, or county) (State): A. A. Co, Md

DATE REC'D BY LOCAL REG. 10/3/49

REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR ADDRESS: D. L. Brown & Son 108 W. Montgomery St

MARYLAND STATE DEPARTMENT OF HEALTH

09416

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park; MARYLAND LENGTH OF STAY (In this place) 9 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 215 Elizabeth Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park; STREET ADDRESS (If rural, give location) 215 Elizabeth Ave.

3. NAME OF DECEASED (Type or Print): (First) Rodney (Middle) (Last) TAYLOR

4. DATE OF DEATH: (Month) Oct. (Day) 1 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: Mar. 28, 1939

9. AGE last birthday: 10 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: Irving Taylor, Sr

14. MOTHER'S MAIDEN NAME: Lauretta Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lauretta Taylor

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Suffocation

916.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Burning Home

180 (c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home

(CITY OR TOWN) Patapsco Park (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) Oct. (Day) 1, (Year) 1949 (Hour) 5:30 a.m.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? Home on fire and got trapped

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Geoffy M.D., Deputy Medical Examiner, Annapolis Md. 10-1-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 10/4/49; NAME OF CEMETERY OR CREMATORY Mt Calvary; LOCATION (City, town, or county) (State) A A Co., Md

DATE REC'D BY LOCAL REG. 10/3/49; REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR 108 W. J. L. Brown & Son Montgomery St ADDRESS

VS. A15A

09418

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
LENGTH OF STAY (In this place) 18 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS S. Crain Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
STREET ADDRESS (If rural, give location) S. Crain Highway

3. NAME OF DECEASED (Type or Print): (First) VACLAW (Middle) (Last) VACEK Jr.

4. DATE OF DEATH: (Month) Oct. (Day) 24 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7/22/1881

9. AGE last birthday: 68 yrs. | If under 1 year: Months | Days | If under 24 Hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Blacksmith

11. BIRTHPLACE (State or foreign country): CZECHOSLOVAKIA-

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: VACLAW - VACEK.

14. MOTHER'S MAIDEN NAME: MARY - SCHUCOTA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-20-8897

17. INFORMANT: MRS. Anne Vacek (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage, due to a	
976 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 164c	(b) self-inflicted wound, with a 30-32	Instant
	(c) rifle - through frontal bone.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY Farm (CITY OR TOWN) Severn (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 24-1949-3½ p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Suicide

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Gustave K. Fowler M.D. Assistant Deputy Medical Examiner - Glen Burnie, Md. - 10/24/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Oct. 27/49
NAME OF CEMETERY OR CREMATORY: Glen Haven
LOCATION (City, town, or county): Ritchie Highway (State): Md.

DATE REC'D BY LOCAL REG. 10-26-49
REGISTRAR'S SIGNATURE A.W. Hedrick
24. FUNERAL DIRECTOR: Krause Funeral Home ADDRESS: 1216 S. Charles St. Balto

09419

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural give location) 510 Burnside

3. NAME OF DECEASED (Type or Print) (First) Frances (Middle) Agnes (Last) Vodak
4. DATE OF DEATH (Month) 10 (Day) 14 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 1/11/1887
9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? N.S.A.
13. FATHER'S NAME James F. Shemanek
14. MOTHER'S MAIDEN NAME Anna Kalol
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT John Vodak Eastport Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) multiple Myelomo — INTERVAL BETWEEN ONSET AND DEATH 3 mos.

203 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

55e (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.22, 1949, to 10-14, 1949, that I last saw the deceased alive on 10-14, 1949 and that death occurred at 1:10 P m., from the causes and on the date stated above.

SIGNATURE E. Lin Loedt. (Degree or title) MS. ADDRESS Eastport, Md DATE SIGNED 10-15-49.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 10-17-49 NAME OF CEMETERY OR CREMATORY St Mary's Cemetery LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Oct. 16, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09420

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glendale | LENGTH OF STAY (in this place) 6 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 + Annapolis Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Elsie (Middle) Clower (Last) Walker.

4. DATE OF DEATH (Month) Oct. (Day) 21 (Year) 1949

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH June 20 1875 | 9. AGE last birthday 74 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Pa. | 12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME Samuel Clower

14. MOTHER'S MAIDEN NAME Caroline Sloan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS Mrs. Carolyn Lindsay.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-Vascular disease	2 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Haemorrhage	9/14/45
331 93d	(c) Hypertension	1917

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1947, to 10/21, 1949, that I last saw the deceased alive on 10/21, 1949, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Chas. L. Ball Jr MD | Linthicum | 10/21/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 10-25-49 | NAME OF CEMETERY OR CREMATORY Hillcrest Cem. | LOCATION (City, town, or county) (State) Clearfield, Clearfield Co. Pa.

DATE REC'D BY LOCAL REG. 10/21/49 | REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR Thomas W. Singleton | ADDRESS Glen Burnie

RECEIVED
OCT 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

09421

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County ANNE ARUNDEL
City or town ~~BALTIMORE~~ Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs.
Hospital, institution, or street address where death occurred:
HILTOP Rd. + WATERVIEW DRIVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town ~~Balto 26~~ Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. HILTOP Rd. + WATERVIEW DRIVE
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME HARRY A. WEAVER

3. (b) Social Security Number no

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced WIDOWER
6.(b) Name of husband or wife MOLLIE WEAVER
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) DEC. 1, 1881

8. AGE: Years 67 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)
10. Usual occupation CANDY SALESMAN
11. Industry or business VIRGINIA DARE
FATHER
12. Name CHARLES WEAVER
13. Birthplace BALTO. Md.
MOTHER
14. Maiden name MARGARET P
15. Birthplace BALTO Md.
16. Informant MRS. ROSS LARKIN
Address HILTOP Rd. + WATERVIEW DRIVE
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof OCT. 17-49 (month) (day) (year)
Cemetery or crematory BALTIMORE CEMATERY
Location EAST END of NORTH AVENUE
18. Funeral director KRAUSE FUNERAL HOME
Address 1216 S. CHARLES ST.
19. 10/17 1949 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/49 19..... at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 19..... to 10/14/49 19.....
and that I last saw him alive on 10/14/49 19.....
Immediate cause of death Coronary occlusion — DURATION 2 weeks
Due to Arteriosclerosis
Due to
Other conditions Senility
420.1 94a (Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Isaac Miller M.D. M. D. or other
Address 1221 S Charles St Date signed 10/17/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09422

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: A.A. County

City or town: GLEN BURNIE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: FURNACE BRANCH RD

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MD County: A.A. Co.

City or town: GLEN BURNIE
(If outside city or town limits, write RURAL and give nearest town)

Street No.: FURNACE BRANCH RD
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: CHARLES A. WICKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: JENNIE WICKER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN 28 1887

8. AGE:

Years	Months	Days	If less than one day
62	8	13	..... hrs. ..... min.

9. Birthplace: BALTO MD
(Town, county, and state)

10. Usual occupation: MACHINEST

11. Industry or business: AMERICAN CAN CO

FATHER
12. Name: THOMAS WICKER
13. Birthplace: AUSTRIA

MOTHER
14. Maiden name: NOT KNOWN
15. Birthplace: NOT KNOWN

16. Informant: JENNIE WICKER

Address: FURNACE BRANCH RD BOX 167 BROOKLYN MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: Oct 14-49 (month) (day) (year)

Cemetery or crematory: HOLY CROSS CEM

Location: A.A. Co.

18. Funeral director: Bernard C. Hurley

Address: 121 E West St

19. 10-12 1949 (Date rec'd by registrar) C. W. Hopkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT 11 1949, at 10:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from JUNE 1949, to ~~SEPT~~ OCT 1949 and that I last saw him alive on OCT 7 1949

Immediate cause of death: ACUTE CORONARY THROMBOSIS

Due to: UNKNOWN

Due to: .....

Other conditions: 420.1 94a (Include pregnancy within 3 months of death)

DURATION: .....

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H F Zangara, M.D. M. D. or other

Address: Glen Burnie, Md Date signed: Oct 11, 1949

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09423

Reg. Dist. No. 29

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Laurel
LENGTH OF STAY (in this place) 23 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Laurel
STREET ADDRESS (If rural, give location) Fort Meade Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lilia	Bell	Weiss	October	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	W	married	Aug. 8, 1896	53 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Shipley	Jane Albon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no		Elsie Weiss Laurel Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Generalized Lymphosarcoma	Jan 1948
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Lymphosarcoma Cervical Gland	
	(c) "	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4-27-48 - 6/2/49	Extensive involvement Abdominal Organs	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3 1 ....., 19 49, to 10 11 ....., 19 49, that I last saw the deceased alive on 10 11 ....., 19 49, and that death occurred at 6:55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. G. Warren Laurel Md 10 13 49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/14/49	Ivy Hill Cemetery	Laurel, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct 14-1949	Mara Pashley	DeWitt Donaldson	Laurel Md